mentalwelfare commission for scotland

A Question of Balance

Report from our visits to people being given compulsory mental health care after committing an offence in Scotland
July 2009 to March 2010

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Introduction

Who we are and what we do

The Mental Welfare Commission is an independent organisation working to safeguard the rights and welfare of everyone with a mental illness, learning disability or other mental disorder. Our duties are set out in mental health and incapacity law.

We are made up of people who have understanding and experience of mental illness and learning disability. Some of us have worked in healthcare, social care or the law. Some of us are carers or have used mental health and learning disability services ourselves.

We believe that everyone with a mental illness, learning disability or other mental disorder should

- Be treated with dignity and respect.
- Have the right to treatment that is allowed by law and fully meets professional standards.
- Have the right to live free from abuse, neglect or discrimination.
- Get the care and treatment that best suits his or her needs.
- Be enabled to lead as fulfilling a life as possible.

Our work

- We find out whether individual treatment is in line with the law and practices that we know work well.
- We challenge those who provide services for people with a mental illness or learning disability, to make sure they provide the highest standards of care.
- We provide advice, information and guidance to people who use or provide services.
- We have a strong and influential voice in how services and policies are developed.
- We gather information about how mental health and adults with incapacity law are being applied. We use that information to promote good use of these laws across Scotland.

Our visits

One of the ways in which we monitor individual care and treatment is through our visits programme. We visit people in a range of settings throughout Scotland: at home, in hospital or in any other setting where care and treatment is being delivered.

This report reflects our findings from a programme of national themed visits to people being given compulsory mental health care and treatment after committing an offence. The aim of national themed visits is to enable us to assess and compare care and treatment for particular groups of people across Scotland. Our aim is to

help services learn from good practice and to respond to any issues that are identified. This report provides an overview of our findings from a series of visits we undertook across Scotland between July 2009 and March 2010.

Legislative background

A small number of people who have mental ill-health or learning disability commit offences. The law provides ways to make sure that they receive care and treatment rather than punishment. The laws that apply are:

- The Criminal Procedures (Scotland) Act 1995 ("the 1995 Act"). This Act provides ways for the courts to impose orders for care and treatment.
- The Mental Health (Care and Treatment) (Scotland) Act 2003 ("the 2003 Act"). This Act governs the way people are treated after the courts have made the orders.
- The Adults with Incapacity (Scotland) Act 2000 ("the 2000 Act"). This Act allows for people to have welfare guardians after committing offences. We did not include these people in this report.
- The Human Rights Act 1998. This Act incorporates the articles of the European Convention for Human Rights (ECHR) into the law in Scotland.

Why we visited

We wanted to find out how the principles and provisions of the 2003 Act were being used in the care and treatment of the individuals we visited. In particular, we wanted to make sure that there was a good balance between helping people to recover and making sure that they and others stayed safe. This can be a difficult balance to get right whenever the 2003 Act is used, but is even more difficult for people who have committed offences.

Who we saw and what we focussed upon

We carried out a series of visits to people subject to mental health care and treatment through the 1995 and 2003 Acts. Our main areas of focus were:

- Information and participation: were people involved enough in their own care and treatment and were they able to get the help and support they needed to do this?
- Least restriction of freedom: was the level of security appropriate to address the assessed level of risk?
- "Reciprocity": were people getting care and treatment that met their needs? We were particularly interested in care plans that promoted recovery in the context of the offending behaviour associated with their mental disorder. We also wanted to look at physical health care and the monitoring of high doses of medication for mental illness.
- Lawful medical treatment: was part 16 of the 2003 Act being used properly to make sure that people were being treated with their consent or with an independent opinion from a "designated medical practitioner" (DMP)?

- Lawful use of restrictions on privacy and dignity: were "specified persons" restrictions being used appropriately if people were being searched or having visitors or communication restricted?

What we did after our visits

We visited a total of 337 individuals who were subject to various orders after committing offences. Following our visits, we used the information we collected to produce this report. We also took action in individual cases if we had concerns. Where we thought that an individual's care and treatment was not in line with the law or best practice, we raised this with care staff and followed up any recommendations we made. We took action in 78 (23%) of the 337 individual cases we examined.

People we visited

Category of order

Our aim was to see all people who were on long term orders with "restricted status" (i.e. where Scottish Ministers must approve some aspects of their care). Also, we visited people who did not have restricted status but who had been treated for more than a year. Table 1 shows the details of the people we visited.

Table 1: Category of order for the people we visited

Type of order	Number of people	Percentage of the people we visited
Compulsion order with restriction order (CORO)	197	59%
Compulsion order (CO)	109	32%
Transfer for treatment direction	24	7%
Treatment order	4	1%
Hospital direction	3	1%
Total	337	100%

Of these people, 76 (23%) were in the community, 37 of whom were on conditional discharge from an order with restricted status. There were 34 people subject to community compulsion orders and five whose detention in hospital had been suspended.

We examined case records of all 337 people. We offered interviews to all 265 people who were present when we visited. Of these people, 231 agreed to meet with us.

Diagnosis

The majority of people had a diagnosis of mental illness. There were 276 people (82%) with this category of mental disorder. Fifty two people (15%) had a diagnosis of learning disability and 50 (15%), a diagnosis of personality disorder. There were more people with a learning disability in this group than within the general population. People with learning disability make up 10% of those subject to civil compulsion but no more than 4% of the general population. This is consistent with other reports of over-representation of people with learning disability within forensic populations. There were two people with a diagnosis of Asperger's syndrome .

A small but significant number of individuals had more than one diagnosis, with 34 having mental illness and either learning disability (11) or personality disorder (23). Three people had mental illness, learning disability and personality disorder.

Our findings

Overall impressions

There were many positive findings from our visits. We were pleased to see good attention to the principles of the 2003 Act. Most people participated in their own care and were well supported by independent advocacy. The level of security appeared appropriate in most cases and we found evidence that the principle of least restriction of freedom was being observed. Care plans were mostly holistic and professional input was good.

There are some aspects of care under this legislation that could improve, in our opinion. We have produced some key messages to address these.

Key messages

1. There is good evidence that individuals are involved in their care and treatment and have good access to advocacy to support them. Practitioners could do more to help people nominate a named person and make advance statements. They should supply written information on these provisions and explain the provisions to individuals under their care
2. In general, people appear to be managed in the appropriate level of security. Most risk assessments were good but up-to-date risk assessments should be readily available for all staff.
3. Care plans are generally good and there was good professional input to people's care. Social work input needs to improve. The 2003 Act requires that each of these individuals has a designated Mental Health Officer (MHO) appointed by the local authority. Designated MHOs should ensure that each individual has a social circumstances report (SCR) carried out as required by the 2003 Act unless they can demonstrate doing so "would serve little, or no, practical purpose."

4. There is still not enough evidence of physical health reviews for people with severe and enduring mental illness. Responsible medical officers and general practitioners should work together to make sure that all such people are registered and receive an annual review of physical health. The outcome should be available to the individual and appropriate members of the care team. There must be specific action to address the risks of high dose antipsychotic medication.
5. Some people appeared to have been given medical treatment that was not properly authorised by the law. Changes in medication should trigger a review of statutory treatment forms to ensure that all treatment prescribed is authorised. Where medication is covered by a "T2" form certifying the person's consent, the RMO must ensure that the individual has capacity and is giving informed consent to treatment.
6. The placing of additional restrictions on an individual already subject to detention should be very carefully considered. Where they are required, implementation of "specified persons" regulations must be carried out lawfully, on a patient centred basis and with good reason.

Information and participation

Key Message 1

There is good evidence that individuals are involved in their care and treatment and have good access to advocacy to support them. Practitioners could do more to help people nominate a named person and make advance statements. They should supply written information on these provisions and explain the provisions to individuals under their care

What we expect to find

Principles of the 2003 Act include participation of the individual, information and support to allow the individual to participate and information and support for carers. We expect to see evidence that individuals are involved in care planning and have the opportunity to take advantage of specific provisions, notably named persons, advocacy and advance statements.

What we found

Participation in care planning

We comment on the quality of care plans later in this report. One of the most important aspects of good care planning is that service users feel valued and are actively encouraged to participate as fully as they can in their care and treatment.

We were pleased that of the 77 people seen in the community, 88% felt that they were involved in their care planning, while 80% of the 260 individuals seen in

hospital shared this view. In 82% of the care plans reviewed, there was evidence that the individual was involved in the process and that the plans were responsive to their changing need.

One individual receiving care in the community commented:

"My care plan is excellent. My family are involved and listened to and I am confident that if any problems arise, they will be listened to"

Named persons

The 2003 Act gives individuals the opportunity of having a named person who must be informed and consulted about certain aspects of their care.

We found that 23% of individuals did not have a named person, 23% had a default named person, and 54% were documented as having nominated a named person. We accept that for this group of people there may be a higher proportion of people who do not wish to have a named person or there is no suitable person available, but we believe that this proportion can be reduced. Practitioners should make sure that individuals know they can appoint a named person.

Independent advocacy

Under section 259 of the 2003 Act, all individuals with a mental disorder have a right of access to an independent advocate and there is a duty on Health Boards and local authorities to ensure that independent advocacy services are available.

Access to advocacy was fairly consistent across Scotland. We were pleased that the vast majority of people knew about advocacy. There was a small number of people who knew about advocacy but did not appear to know how to access the services, and a small number where no information was available.

We found that 91% of the individuals knew about advocacy services and 87% had access to advocacy. An advocacy service had been used by 56%. This group of individuals appear to have better access to advocacy services compared with the people subject to long term detention that we visited in 2008 (81%, 72% and 43% respectively). When we looked specifically at those with a diagnosis of learning disability this was even higher, with 92% having access to advocacy and 79% having used the service.

The high level of access to advocacy is positive. NHS Boards and local authorities should continue to support and extend the use of advocacy services.

Advance statements

Sections 275 and 276 of the 2003 Act allow an individual to make an advance statement. This is a written statement setting out how they would wish to be treated, or wish not to be treated, for mental disorder should their ability to make decisions about treatment for their mental disorder become significantly impaired. The advance statement is one way of ascertaining the individual's wishes and feelings about future treatment.

We found that 57% of the individuals we visited were aware that an advance statement could be made, which is higher than our findings from the individuals on long term detention under civil procedures (31%). Half of those who knew about advance statements had made one and a small minority, 5%, had had their advance statements overridden. However, these overrides were covered by appropriate treatment certificates, with explanations for the override. We receive notification of all overrides and review the circumstances and reasons given for them.

Least restriction of freedom

Key Message 2

In general, people appear to be managed in the appropriate level of security. Most risk assessments were good but up-to-date risk assessments should be readily available for all staff.

What we expect to find

Balancing the risk to the individual and others with the individual's right to liberty is one of the most difficult aspects of care and treatment. We expect to see that restriction of liberty is lawful and proportionate. We wanted to make sure that any restrictions were based on a well-conducted risk assessment and that staff were all aware of any risks. We also looked at the level of security in which people were managed. The level of security should reflect the degree of risk and should not be more than necessary.

What we found

Risk assessment

Good risk assessment and risk management procedures need to be in place. A balance must be struck between the reduction of risk and the provision of a therapeutic in-patient environment with the least restriction being placed on service users. For patients on suspension of detention or conditional discharge, up to date risk assessments and risk management strategies are essential for both the individual's health and safety and, where relevant, the safety of other people.

Risk assessments were readily available for a large percentage of the 337 people seen: 89% had one in place when we visited. However, there was no risk assessment available on the day of the visit for 48 people. Of this group, 39 were in hospital and 9 were in the community, 4 of whom were on conditional discharge. We were told that, for 9 of the hospital group, new or re-assessments were currently being undertaken. We have followed up those individuals on conditional discharge whose risk assessment was unavailable with the Mental Health Division of the Scottish Government.

It may be that risk assessments had been undertaken and were documented somewhere but not readily available in case records. As a result, staff working with individuals on a day-to-day basis may not have been aware of assessed risks and of agreed actions they needed to take to address any risk the individual may pose.

We looked at when risk assessments were most recently updated. We found that 57% of all people had an updated risk assessment within the last six months. For people in hospital, 80% had an updated risk assessment within the last year. People in the community were slightly less likely to have an updated assessment (76%).

Good risk assessment practices help identify risks faced by or posed by individual service users. Individual care plans should provide a basis for the appropriate management of these risks. The environment, operational processes and available resources of any in-patient service should be appropriate to meet the assessed care needs of individual service users, including the management of risk. There should be a clear local understanding of the degree of risk that can be safely managed in any particular in-patient service. No ward can be entirely risk free and the involvement of service users and carers is essential in developing a service that strikes the right balance between risk management and the provision of a safe environment without undue "blanket" restrictions reducing the quality of life for all.

Level of security

Security is an integral part of any service for people with mental disorder who have committed offences. The need for a particular level of security can be governed by a number of factors including the nature of the offence for which the individual has been convicted or placed on a mental health order, their assessed risk to themselves and to others including the wider public, and the severity of the mental disorder.

In our review, 103 people were in high security care, 41 in medium secure care and 65 in low secure care. There were 52 people in non-forensic settings, (including some learning disability settings) and 76 were in the community.

Twenty six people had either clear plans to move or their current situation was being actively reviewed. Two people stated that they did not wish to move from their present setting, the State Hospital, despite no longer requiring high secure care, in one other case relatives were concerned about a potential move to lower secure care. Five people in the State Hospital had been successful in their appeals to the Tribunal against excessive security and were awaiting transfer.

Overall, we found that levels of security were appropriate. Where the level of security could be reduced, we were pleased to see that there were plans in place. Examples of our visitors' comments were:

"Discussions about a move to lower security but there are family concerns about this. His father believes that his son gets the most appropriate care in the State Hospital. The risk assessment identifies that X needs a high level of supervision but could move on to a medium or even low secure setting, although he has consistently made

his view clear that he does not wish to leave the State Hospital. Case notes contain the question whether X might actually be 'less restricted' at the State Hospital than in these other settings."

"Y has been very stable for some time now and does not require to be in a medium secure unit. Efforts are being made to move him to a low secure unit in the area where he comes from, as soon as the bed becomes available."

"Care plan suggests that Z in his current condition is ready for discharge into community, but this is delayed due to the unavailability of a suitable placement. One placement was identified to move the patient into the community but the patient rejected it. Attempts are being made by the team to find a suitable placement."

Reciprocity – care planning and professional input

Key message 3

Care plans are generally good and there was good professional input to people's care. Social work input needs to improve. The 2003 Act requires that each of these individuals has a designated Mental Health Officer (MHO) appointed by the local authority. Designated MHOs should ensure that each individual has a social circumstances report (SCR) carried out as required by the 2003 Act unless they can demonstrate doing so "would serve little, or no, practical purpose."

What we expect to find

The principles of the 2003 Act include the importance of providing services to people who are (or have been) subject to compulsion. We expect to see a good range of services, covered by a comprehensive care plan. Regular contact with relevant practitioners ensures that the care is delivered as planned and that the person's needs are reviewed.

What we found

Care planning

Assessment and care planning should be a partnership between the patient, carer(s) and relevant others, health professionals and other relevant disciplines/agencies including the local authority. It should provide a holistic approach to the care and treatment of an individual and address all their identified needs and not just their apparent treatment needs. It should be clearly focussed on recovery.

For individuals in hospital, the culture of a ward is set by the people who work there and the values to which they aspire. "Good ward culture" means a ward where relationships between staff, service users, relatives and carers are positive and there is a clear vision shared by all of how to help the individual using services to move forward.

Whether in hospital or in the community, we would expect to find recorded evidence of care planning for all individuals. In addition, we would expect most people to be aware of their care plan and feel involved. We commented positively on this in our section on information and participation.

Of the 337 people visited, 301 individuals were subject to the Care Programme Approach (CPA) with 88% of people in the community and 90% in hospital having their care plan managed and reviewed through this process. In 84% of the care plans we looked at, there was evidence of multidisciplinary involvement from a range of health professionals. However, in only 30% of these care plans was there written evidence of social work participation and involvement.

In 32% of cases there was no recorded evidence of either social work or mental health officer (MHO) involvement in reviews, 53% had evidence of MHO involvement and 15% had evidence that both MHO and social work were involved.

Frequency of contact with professionals

> The level of support and monitoring required will vary depending on individual need and may change over time as an individual's mental state and circumstances alter. It is important that service users have adequate contact with their care team to ensure that services can identify and respond to changes in need.

We looked at the level of contact with care team members and found, not surprisingly, that the named nurse was the most frequent point of contact with the care team. Also, of the 260 people in hospital, 76% were being seen at least monthly, and the remaining 24% at least quarterly, by their responsible medical officer (RMO).

There was evidence of good support for the 76 people who were in the community. Of these, 95% of people were seen by their community nurse at least once a month and 76% were seen by their responsible medical officer (RMO) on a similar frequency.

We found that mental health officer (MHO) involvement was much less than this. The Act requires that the local authority appoint a designated MHO for each person subject to compulsory powers beyond an emergency detention under the Act. One important task for the MHO is to produce a social circumstances report (SCR).

The Commission, in its good practice guidance on the preparation of SCRs, recommends that "An annually updated SCR should be provided by the designated MHO for all people subject to long term detentions. Exceptions to this would be where there are agreed alternative review arrangements in place, e.g. Care Programme Approach reviews that involve MHOs or MHO reports prepared to support decisions to extend/vary orders" (MWC 2009). Even in this situation, an updated SCR may be helpful.

Only 58% of people had regular contact with their MHO, by which we mean at least monthly. Of the 306 people who were subject to a CO or a CORO, 223 (73%) had no SCR on file, and only 61 (20%), had an SCR dated after 2007. For the 37 people on

conditional discharge, 76% received regular MHO input. Given the status of this patient group, we would have expected a higher level of MHO contact.

As part of the statutory role of the MHO, SCRs should be provided following a significant event. In line with our guidance, at a minimum, an updated SCR should be available to support an individual biennial statutory review

Reciprocity – attention to physical health

Key message 4

There is still not enough evidence of physical health reviews for people with severe and enduring mental illness. RMOs and general practitioners should work together to make sure that all such people are registered and receive an annual review of physical health. The outcome should be available to the individual and appropriate members of the care team. There must be specific action to address the risks of high dose antipsychotic medication.

What we expect to find

Attention to physical health is one aspect of care that has given us cause for concern. It forms an important part of "Delivering for Mental Health" (Scottish Executive 2006). People with severe and enduring mental illness have poorer physical health than the general population and have a reduced life expectancy. We wanted to make sure that the physical health of the people we visited was being given appropriate attention.

High doses of medication for mental illness carry health risks. The Royal College of Psychiatrists has produced guidance on the monitoring needed for high doses of antipsychotic drugs (RCPsych 2006). We wanted to make sure that practitioners were following this guidance.

What we found

Review of physical health

Studies have consistently shown increased mortality in people with mental disorders. They attributed the causes for increased mortality to the effects of the mental disorder and to the patient's altered lifestyle.

Responsible medical officers have a duty to take all aspects of their patient's care into account. It is known that high rates of smoking and obesity and the side-effects of psychotropic drugs mean that these patients are at increased risk of developing heart disease, chronic obstructive lung disease, chronic liver disease and diabetes. This group of people have higher levels of risky behaviour such as injecting drugs, excess alcohol consumption and unprotected sex. These factors, in combination with problems experienced in gaining access to adequate health and social care services, result in significantly reduced physical and mental health.

There should be a review of physical health at least once every 15 months. We found a review in 176 cases (52%), 160 (47%) of them within the last year and 16 (5%) of them more than a year ago. These figures are slightly lower when compared to those found during our review of people subject to long term detention carried out in 2008. There were 161 people who did not appear to have been reviewed in respect of their physical health; 63 of whom were in the community and 98 in hospital.

In most cases we were advised by staff that all the patients had annual checkups, but we could not find the evidence for this. Most of the individuals in the community reported that they have easy access to their GP, but the reviews were not recorded in the case notes we saw. In a minority of cases, physical health check up was offered, but this was refused by the service users.

It may be that some people had had a review of their physical health but that it was not documented in the case records available to staff who were providing most of their care and treatment. If this is true, the health review had limited usefulness. An annual review helps to bring together information, which will allow the patient's key worker and the GP to review relevant primary care issues.

Monitoring of high dose antipsychotic medication

> All people receiving high dose anti-psychotic medication should have high dose monitoring initiated at the start of treatment. This includes people who may be subject to high dose treatment if "as required" medication is given alongside regular prescriptions. The risks of high dose antipsychotic drugs include heart and metabolic problems and regular blood tests and electrocardiographs are recommended.

Of the 41 individuals who we viewed as requiring high dose antipsychotic monitoring (40 in hospitals and 1 in the community), only 33 (80%) had evidence that this was being carried out. This is consistent with our findings from our reviews of people on long term detention.

The most common reason for not initiating high dose monitoring is that the clinical teams have not taken account of the potential to go over the maximum recommended dose, because of 'as required' medication. Regular clinical pharmacy review would help to identify and monitor such people.

Lawful medical treatment

Key Message 5

Some people appeared to have been given medical treatment that was not properly authorised by the law. Changes in medication should trigger a review of statutory treatment forms to ensure that all treatment prescribed is authorised. Where medication is covered by a "T2" form certifying the

person's consent, the RMO must ensure that the individual has capacity and is giving informed consent to treatment.

What we expect to find

Part 16 of the 2003 Act provides safeguards for treatment of mental disorder. Part 5 of the Adults with Incapacity Act 2000 also has provisions for medical treatment. It is essential that medical treatment complies with these legal provisions. Where the person "consents", we expect the person to understand the nature, purpose and likely effects of the treatment. Where the person does not consent or cannot consent, we expect to see an independent opinion authorising treatment. In all cases, we expect proper legal documentation to be in place.

What we found

Of the 302 individuals who require their medication to be covered by an appropriate certificate:

- 62% consented to their medication in writing and had a "T2 form" in place.
- 31% were found to be unable to consent or objected to their treatment; their treatment was therefore authorised by a certificate completed by a designated medical practitioner ("T3 form") and 2% had both T2 and T3.
- A small number of people who were unable to consent to their treatment also had "Section 47" certificates under the Adults with Incapacity Act in place to authorise their treatment for coexisting physical ill-health.

We found that 88% of the individuals had their prescribed medication appropriately covered by T2/T3/S47 certificates.

Twenty-eight individuals (9%) were found to be receiving treatment not authorised by an appropriate certificate. Seven people had obsolete treatment forms from the previous Act (forms 9 and 10), 6 had no treatment certificates, 12 had T2 forms which did not cover their current treatment and 3 had T3 forms that did not cover their current treatment. In 9 other cases (3%), the data collected was not conclusive about the appropriateness of the treatment certificates. In all cases, we took further action to make sure that people were receiving treatment lawfully.

Of the 193 individuals with T2 forms, we found problems in 16 (8%) of these cases. In some cases, the form did not cover the present treatment. In other cases, we did not think the person was giving informed consent. Examples of comments from our visitors were:

"Certificate covers clozapine and lithium, patient now on olanzapine. Spoke to RMO in ward, he will have this updated today, patient was able to tell me what medication he was on and that he was happy and willing to take this."

"Oral zuclopenthixol covered by T2. I asked J... whether he thinks he has a mental illness. He said what is said to be (his) delusions is fact but he can't prove it. Spoke of seeing the world in a different way. I asked him if he thinks zuclopenthixol is helpful to him. He said it does not make any difference. He became irritable when I asked him if he consented to take the medication. He said he takes it orally because

he knows if he does not he will be given a "jag in the arse". I spoke to the RMO by telephone. It seemed to me that J was not giving free informed consent to treatment. Dr said he would review his consent to treatment with him."

Of the 100 individuals with T3 forms, we found problems in 13 cases (13%). For example:

"The certificate covers any one oral and any one depot antipsychotic regularly and also any one antipsychotic on an as required basis. Patient is currently on risperidone 3mgs twice daily chlorpromazine 50 mgs four times daily, zuclopenthixol decanoate 250mgs I/M 2 weekly and chlorpromazine 50mgs if required up to four times daily. He is on one extra oral antipsychotic which is not covered by the T3."

There were 4 individuals with a valid S47 certificate. We identified one individual who had no S47 certificate, when this was needed.

Lawful use of restrictions on privacy and dignity

Key message 6

The placing of additional restrictions on an individual already subject to detention should be very carefully considered. Where they are required, implementation of "specified persons" regulations must be carried out lawfully, on a patient centred basis and with good reason.

What we expect to find

The placing of additional restrictions on an individual already subject to detention should be very carefully considered. Where they are required implementation of "specified persons" regulations must be carried out lawfully, on a patient centred basis and with good reason. Article 8 of the European Convention for Human Rights stipulates that interference with a person's right to privacy and dignity must be lawful and proportionate.

The 2003 Act has regulations which govern the additional restrictions which can be placed on patients who are subject to detention in hospital. These cover safety and security, use of telephones and correspondence. In the State Hospital, all patients are automatically classed as specified persons and therefore their access to telephones and use of correspondence can be restricted, and they and their belongings can be searched or they can be asked to give urine samples for testing. In medium secure settings, all patients are automatically specified for safety and security only. In all other settings, detained patients have to be made a specified person on an individual basis and for each particular restriction if it is thought necessary.

What we found

We found that generally, with the exception of the State Hospital and some medium secure wards, the regulations were not well understood and on many occasions, the RMO had not documented good reasons for applying them.

We found that the State Hospital used these measures well. Despite the automatic specification of State Hospital patients, many of them are not subject to additional restrictions as it is not deemed necessary. The fact that a patient is specified does not imply that the authorised restrictions have to be imposed.

For people in medium secure settings, there is automatic specification for safety and security alone. The RMO has to determine on an individual basis whether the additional restrictions for telephones and correspondence should apply and specify the person accordingly. We found 9 people who appeared to have these additional restrictions without the appropriate paperwork to authorise them. We raised these issues with the respective RMOs.

For example, during a visit to a person in a medium secure unit, our visitor found a situation where restrictions were applied in a blanket fashion and without the correct documentation.

"We were *told ward policy is that all patients are specified persons and restricted for correspondence. We could not find the appropriate documentation in the person's file."*

For people in low secure or non forensic settings, the RMO has to make an individual determination for each of the three categories if they wish to make them specified persons and impose additional restrictions on them. We found 43 out of 65 people seen in low secure settings were specified in respect of safety and security, 9 of whom were also specified in respect of their correspondence and 5 had their access to telephones restricted. However, for those whose correspondence was restricted, we found no apparent reason why this should be the case. As with those in medium secure settings, we raised these issues with the RMOs. For example:

"*No reasoned opinion attached to RES form. Ward protocol dictates all are specified persons as mail is opened in presence of staff"*

In non forensic settings we found the majority of people were not subject to additional restrictions; only 9 out of 52 people were specified in respect of safety and security, one of whom was also subject to restrictions on their correspondence. A further 3 people were subject to correspondence (2) or telephone (1) restrictions only.

In some settings, staff were not aware of the regulations covering additional restrictions and imposed restrictions without appropriate authority. Our comments included:

"*The issue of 'specified persons' was raised with nursing staff. They were unaware of what this meant and said that their understanding was that where searches were required, male staff will search male patients and female staff will search female patients. There was an apparent understanding that nursing staff have the authority to undertake searches, restrict calls etc."*

"*Not a specified person yet regular urine tests being done for drug screen."*

The regulations do not apply to those on community based orders or conditional discharge (CD). Despite this we found paperwork specifying 3 individuals who were in the community but attended a hospital day service. We raised this with the day hospital manager. For those on CD, Scottish Ministers or the Mental Health Tribunal can attach conditions which may, for example, include procedures to search people or take samples to test for drugs or alcohol.

The Commission has issued guidance on the use of specified persons' regulations (MWC 2010). We strongly advise clinicians and ward staff to familiarise themselves with the contents of the guidance.

Conclusions and further action

There were many positive findings from our visits to the relatively small number of people who committed offences as a result of mental health difficulties or learning disability. If services pay attention to the key messages in this report, care and treatment would improve further and individuals would be treated in line with the principles of the 2003 Act and the articles of the European Convention for Human Rights.

We are taking further action following these visits. We followed up individual matters arising from our visits on 78 occasions (23% of all individuals visited). There were a variety of reasons for further action of this type including issues with consent to treatment - absent or incomplete forms, current treatment not in line with that consented to or authorised, issues to do with the absence of appropriate authority under specified person's regulations, and matters relating to the content of care plans.

We will be visiting people with mental disorder in prisons and will compare our findings from those visits with this report. Also, we are continuing our programme of unannounced visits to make sure that medical treatment complies with the law. We are likely to conduct unannounced visits to make sure that "specified persons" restrictions are being used lawfully and proportionately.

Action points for services

We recommend that managers of services take the following action to address the key messages in this report:

- **Ensure that there are procedures to inform and remind people about their rights to nominate named persons and make advance statements where they have the capacity to do so**
- **Conduct audits of risk assessments to check that they are up-to-date and available for staff who are in regular contact with the individual**
- **Identify a named mental health officer for each individual and audit the completion of social circumstance reports to make sure they meet the requirements of the 2003 Act**

- **Ensure that procedures are in place for regular physical health checks and audit the performance of these checks**
- **Conduct audits of actual or potential high-dose antipsychotic medication to determine whether this is properly identified and monitored**
- **Ensure that all responsible medical officers have access to the Mental Welfare Commission's guidance on Consent to Treatment**
- **Audit compliance with part 16 of the 2003 Act (medical treatment) to make sure that all treatment is prescribed and administered lawfully**
- **Ensure that all responsible medical officers have access to the Commission's guidance on Specified Persons**
- **Audit the use of "specified person" restrictions to ensure that any interference with privacy and dignity is lawful and proportionate**

Definitions

Care programme approach: a mechanism to coordinate input from a variety of practitioners and services. A key worker coordinates all the input and there are regular meetings to discuss progress.

Compulsion order (CO): a disposal by the court where a person with mental disorder is convicted of an offence. It is for six months in the first instance and can be extended by application to the Mental Health Tribunal for Scotland. After that, it is very similar to a civil "compulsory treatment order.

Compulsion order with restriction order (CORO): a disposal by the court where the person is convicted of a serious offence. The person may be detained "without limit of time" and is subject to special restrictions imposed by Scottish Ministers. There is regular review by the tribunal

Delivering for Mental Health: a plan published by the Scottish Executive in 2006 to improve mental health services in Scotland.

Treatment order: an order imposed by the court after the person has been charged but where there has not yet been a trial or final disposal. It lasts until the person is either convicted or acquitted.

References and further reading

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